

Primary Health Care Strategy

Framework Refresh:
2009/10–2012/13

Final – August 31, 2009



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“Realizing possibilities through partnerships”

Purpose of this Framework

The inaugural *VIHA Primary Health Care Strategy 2006/07-2008/09* laid the foundation for an innovative business approach embedded in relationships, partnerships and empowerment.

It is now time to refresh this Strategy and reconfirm our vision, principles, and business model. We have consulted with and received input from our many partners to develop targeted strategies for work in the coming three years. Partners include:

- Primary Care Providers
- VIHA Programs
- VIHA Family Practice Council (FPC)
- Non-Governmental Organizations
- Provincial Primary Health Care (PHC) Council

VIHA PHC Strategy 2006/07 – 2008/09: What Has Been Accomplished

Significant progress has been made against the initial strategies identified in our original document. The following table highlights our areas of investment from the inaugural strategy and the accomplishments to date.

Area of Investment	Accomplishments to Date
Enhancing Current Primary Health Care Organization (PHCO) Services	<p>Base funding for former Primary Health Care Transition Fund projects provided through VIHA operating budget</p> <p>Improved patient experience through advanced access, group visits, patient self-management and satisfaction surveys</p> <p>Improved health outcomes and quality of life, as measured by PHC indicators</p> <p>Increasing operational self sufficiency</p>
Creating Primary Health Care Developer Role and Hiring 5 Positions to Enhance Community Capacity and Engagement	<p>Job description created and approved.</p> <p>Three positions posted and filled.</p> <p>Work to date includes:</p> <ul style="list-style-type: none"> • Coordinating P3 project with District of Sooke to create new Sooke Wellness Centre. • Working with community GPs, VIHA programs and community agencies to create 7 Integrated Health Networks (IHNs). • Facilitating Mount Waddington service renewal initiative towards a primary health care model. • Facilitating work of the Oceanside Taskforce.
Development of Provider Networks	<p>Established VIHA Family Practice Council</p> <p>Fee-for-Service/ Nurse Practitioner (NP) Demonstration projects in Nanaimo, Courtenay, Campbell River; <i>(15 NPs across the island working in PHC)</i></p> <p>Participation of over 300 GPs in the Regional Support Program (242 in PSP, 75 with IHNs, 29 with SARIN, 123 CDMF).</p> <p>Quarterly Chronic Disease Management forums (CDMF) in SI and bi-annual CDMF in CI/NI.</p> <p>Support to develop more Home & Community Care Partnership Projects</p>
Area of Investment	Accomplishments to Date
Enhanced PHC in Priority Communities:	<p>All communities identified in the Inaugural Strategy have been involved in enhancement initiatives:</p> <ul style="list-style-type: none"> • Sooke - Integrated Health Network & Request for Proposal (RFP) for new Community Wellness Centre, Practice

	<p>Support Program, Specialist Services Committee funding for shared care</p> <ul style="list-style-type: none"> • Parksville/Qualicum - Integrated Health Network, pilot Division of Family Practice Community, co-location of Diabetes Education Centre with IHN staff, Oceanside Task Force, Practice Support Program, FPs4BC • Port Alberni - draft RFP for P3 Community Health building; Integrated Health Network; Diabetes recall program (PRIISME), Practice Support Program, FPs4BC • Mount Waddington - reorientation of services to primary health care approach, Practice Support Program, Specialist Services Committee funding for shared care, hiring of Nurse Practitioners for primary care to marginalized populations, FPs4BC • Victoria - 2 Integrated Health Networks, Practice Support Program, Nurse Practitioners, CMHA Bounce Back pilot site, FPs4BC • Nanaimo (Harewood) - Integrated Health Network, Nurse Practitioner Demonstration site, Practice Support Program, Specialist Services Committee funding for shared care, FPs4BC • Tofino - Integrated Health Network satellite site, Practice Support Program, Specialist Services Committee funding for shared care, FPs4BC • Sointula- see Mount Waddington • Campbell River- Integrated Health Network, co-location of primary health care services at SunshineWellness Centre, Nurse Practitioner Demonstration Project site, Practice Support Program, FPs4BC • Comox Valley - co-location of services at new Comox Valley Nursing Centre, Nurse Practitioner Demonstration Project site, Specialist Services Committee funding for shared care, GP sessions for Chronic Pain program, Practice Support Program, FPs4BC • Cowichan Valley- prototype Division of Family Practice, Practice Support Program, diabetes recall program (PRIISME) • Gabriola Island - community planning initiative, FPs4BC, Integrated Health Network satellite site, Practice Support Program
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Area of Investment	Accomplishments to Date
Development of PHC Indicators	<p>Draft indicators developed in 2006</p> <p>Identified key priority PHC indicators to VIHA Board- 2008</p> <p>Integrated Health Indicators will be used for all PHC programs and services</p>
Website development	<p>Website completed Fall 2007, provides general information to the public about all PHC/CDM programs and services</p>
Aboriginal Health PHC Initiatives	<p>Partnered with Inter Tribal Health Authority (ITHA) in Chronic Illness Care Project Phase 1 & 2</p> <p>Specialist Services Committee funds for Shared Care</p> <p>Development and recruitment of Nurse Practitioner positions for aboriginal populations (NI - peds, West Island - psych, West Island - peds)</p> <p>Port Alberni IHN co-located with Tsechaht First Nations</p>
Primary Health Care/IHN Steering Committee	<p>Primary Health Care Strategic Steering Committee met from June 2006 to July 2007</p> <p>In 2007, IHN began development, then IHN Steering Committee established with a renewed primary health care mandate</p>

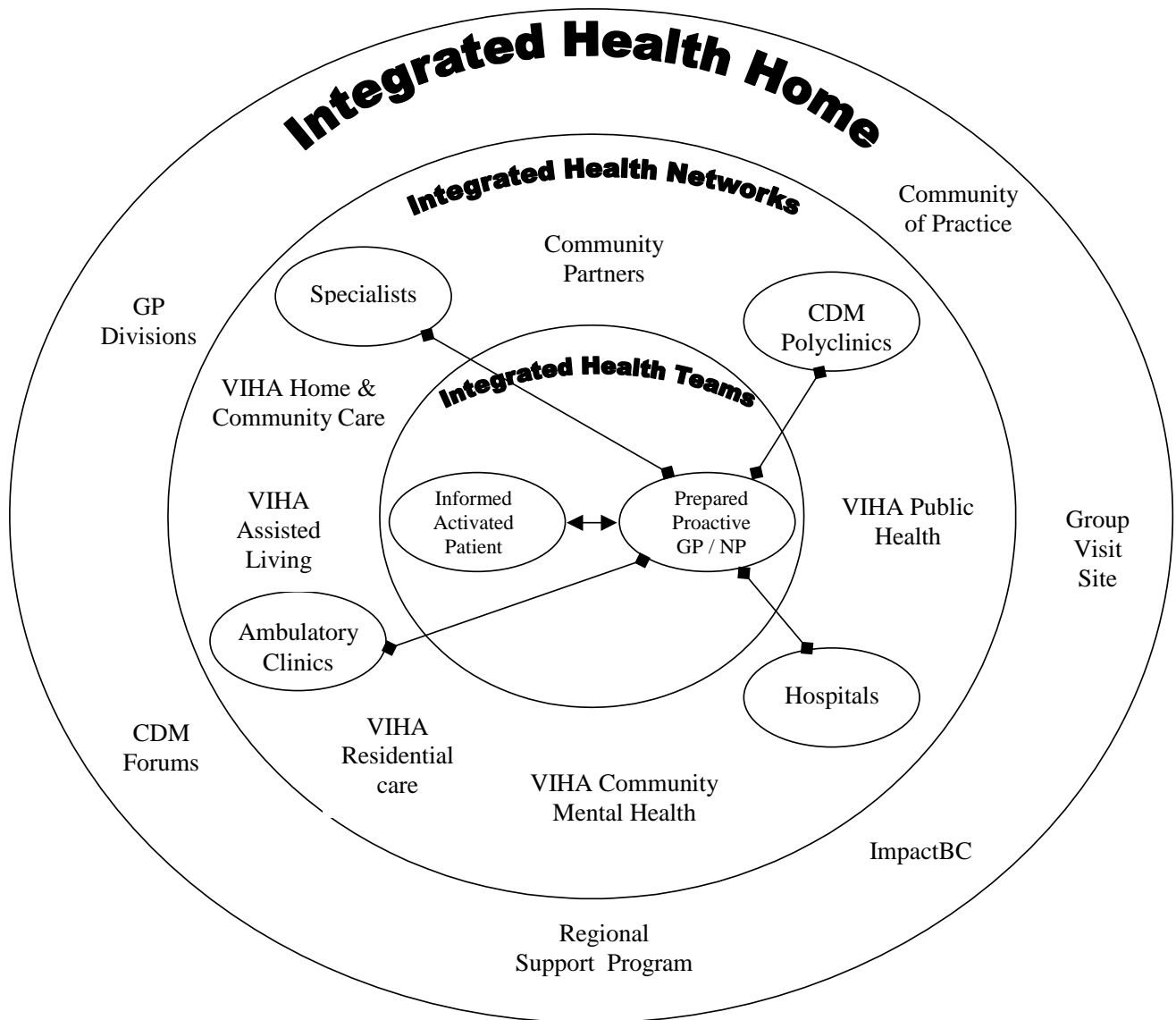
The Foundation: Vision, Definition, Principles

Vision

Our vision for Primary Health Care in our health region is linked to our health authority's vision of: "Healthy People, Healthy Island Communities, Seamless Service".

"Comprehensive, seamless and locally accessible primary health care services delivered by a network of provider teams, integrated into a regional health care system that supports our population to stay healthy, get better, manage illness and disease, and cope with end of life".

This vision focuses on the creation of Integrated Healthy Communities that support our developing Integrated Health Homes and the longitudinal relationship between patients and their doctor/nurse practitioner.



Working Definitions

For this PHC Framework refresh, we continue to use the primary health care working definition developed in the Inaugural Strategy:

The range of supports and services individuals and communities receive on a regular, ongoing basis in order to stay healthy, get better, manage ongoing disease or illness and cope with end of life.

Primary health care is the foundation of the health care system, the cornerstone being the family doctor. Primary health care is defined as the first point of entry into the health care system, the provider of person-focused care from birth to death through the provision of the following services: acute illness care and management, health promotion and education, disease and injury prevention, chronic disease management, palliative and end of life care. Primary health care involves providing these services through teams of health professionals to individuals, families and communities. It also involves a proactive approach to preventing health problems and ensuring better management and follow-up once a health problem has occurred. Continuity of care is a central component of primary health care services. Continuity is enhanced through the longitudinal relationship between the provider and the patient/family throughout the life span. A key partner in the primary health care system is the patient as an active and engaged partner in his/her overall care.

In Practice Teams

In practice teams are interdisciplinary team members attached to the physician's office. Typically these are medical office assistants (MOAs), but in some practices (to include Primary Health Care Organizations), nurses, and other allied health professionals may also be employed. They work collaboratively with the physician to support the care of the patient.

Integrated Health Teams

An integrated health team (IHT) is based on the relationship between the provider and the patient. The IHT is a team of providers, including the doctors, the in-practice teams and the patients themselves.

Integrated Health Networks

An Integrated Health Network (IHN) is a formalized partnership between Integrated Health Teams, selected health care practitioners (for example mental health, home and community care, public health) and community agencies. The IHN interdisciplinary team offers a range of services from assessment, care coordination, individual and group care, and referral to community resources for psycho-social supports.

Integrated Health Homes

An Integrated Health Home provides a supportive environment for Integrated Health Networks. As noted in the diagram, the Integrated Health Home offers a broader perspective on the determinants of health within the community, such as accessible services, safe, supportive and healthy environments and food security. Other aspects of an Integrated Health Home include "a supportive environment for health care practitioners, such as communities of practice and learning opportunities".

Principles

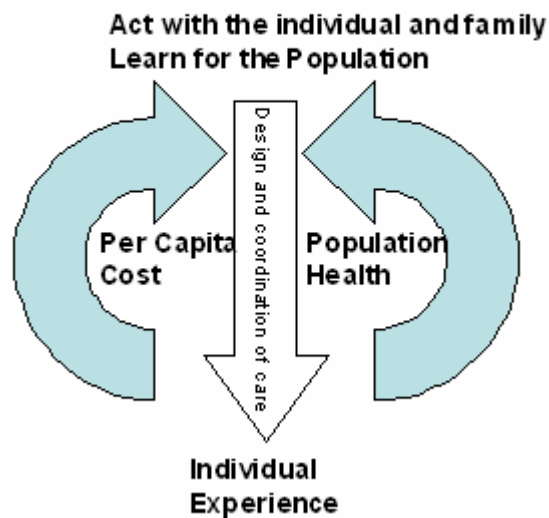
We will achieve our vision by building a system that is:

Comprehensive
Team-based
Seamless and integrated
Accessible
Open to community participation
Appropriate
Accountable
Efficient and sustainable
Designed to increase capacity
Flexible and adaptable

Our Business Model: The Triple Aim Approach

Transformation of our primary health care system requires a societal shift in thinking with the public participating as active, engaged partners in their own health care plans. We need to collaborate with our community partners to support a population health perspective. And, as a growing provincial priority, we need to develop strategies that are economically sustainable with an evidence-based cost-benefit approach. Our Primary Health Care business approach is one that must support transformational change. And we see this opportunity by implementing the “Triple Aim” approach, as proposed by the Institute for Healthcare Improvement (IHI).

Triple Aim Model



The Triple Aim Approach for primary health care has one goal: to optimize the health care system taking into account three key dimensions:

1. the experiences of the individual
2. the health of a population
3. per capita cost for the population

Our ongoing primary health care enhancement business model will utilize these three aims to identify population health needs, to gather individual patient experiences to identify opportunities for integration and partnerships, and to create services that reduce the overall per capita cost per patient whenever possible.

We will do this by:

1. **Ascertaining Population Health Needs:** Working with our VIHA programs and community partners across the Vancouver Island Health Authority to identify community needs within a population health approach (priorities will be directed to those at risk populations and high needs communities with limited resources/services).
2. **Gap Analysis:** Assessing the current structure and resources available in those communities and explore local innovative collaborative solutions with primary health care providers and their communities in a way that simplifies each patient journey through the health care system in a coordinated way. This may include system restructuring and “new ways” of doing business.

3. **Building Partnerships to Close Remaining Gaps**: Where care gaps still exist, we will collaborate with local community government and agencies to create partnership agreements, funding agreements (scalable) and other creative solutions.
 4. **No Increase in Cost per Capita**: Considering new investments through redesign, restructure, and community collaboration that either maintains or reduces the per capita cost to the health care system in order to achieve a sustainable, predictable, stable health care system.
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A Positive PHC Environment

A brief environmental scan exemplifies the positive improvements in the area of primary health care, both provincially and regionally. This is by no means an exhaustive listing, but is meant to give a flavour of the number and types of initiatives underway.

Provincial Initiatives

Provincial Primary Health Care Charter

The Primary Health Care Charter (the Charter) sets the direction, targets and outcomes for the primary health care system in BC. Areas of focus include access, maternity services, disease prevention, disease management, comorbidities, frail elderly and end-of-life.

Provincial Primary Health Care Council

The Provincial Primary Health Care Council has oversight for a coordinated and integrated approach to primary health care transformation as identified in the PHC Charter. The Primary Health Care Council ensures public funding for primary health care is meeting the goals of improved patient health outcomes and system sustainability. The PHC Council is comprised of Ministry of Health Services representatives and Health Authority representatives working collaboratively towards a goal of a strong primary health care system across the province.

General Practice Services Committee (GPSC)

The GPSC was formed under the 2004 Agreement between BC's doctors and the provincial government. The GPSC is comprised of representatives from the BCMA, the Ministry of Health and the Health Authorities. Its role is to develop and implement strategies that allow for optimum use of the cumulative total of \$382 million designated within the 2004/2005 agreement to support improvements in primary care. Current initiatives include new incentive-based fees, Practice Support Program, Divisions of Family Practice and the creation of the Community Health and Resource Directory (CHARD).

HealthLink BC (811)

This new (2008) service provides 24-hour health and social resource information via online telephone and internet services. 811 enables the caller to speak to a nurse about care concerns, a pharmacist about medication questions or a dietitian about nutrition issues.

ActNow! BC

This provincial initiative combines cross-government and community-based approaches to address common chronic disease risk factors through a variety of programs that support healthier eating, physical activity, ending tobacco use and promoting healthy choices during pregnancy. The Ministry of Healthy Living and Sport is responsible for this initiative.

BC Active Aging Plan

Through the Ministries of Health Services, Healthy Living and Sport and the BC Healthy Living Alliance, 2010 LegaciesNow and BC's Active Communities, BC's Active Aging Plan is being operationalized through the BC Healthy Living Alliance.

Child Health BC

Child Health BC, an initiative of the BC Children's Hospital, links regional health authorities, the Provincial Health Services Authority, health professional and care facilities on projects related to excellence in the care of infants, children and youth.

ImpactBC

ImpactBC is a not-for-profit organization specifically established to work across BC's health system in support of system improvement and transformation. ImpactBC represents a strategic alliance between BC's Ministry of Health Services, the BCMA and the provincial health authorities that support health system quality improvement. Current initiatives include Practice Support Program, Innovation Community for Integrated Health Networks, Patients As Partners, and the Health Literacy Collaborative.

Physician Information Technology Office (PITO)

Funded through the Ministry of Health in collaboration with the BCMA, PITO is the not-for-profit program that assists GP offices with implementing an EMR (Electronic Medical Record). Physicians may apply as individual physicians, a practice, groups of practices, or as a Community of Practice.

CDM Tool Kit

The Provincial CDM Toolkit is a web-based software program that provides decision support for health care providers based on clinical practice guidelines. The CDM Toolkit helps to ensure that physicians and their staff provide optimal care to high-risk patients with chronic conditions, such as diabetes, congestive heart failure (CHF), depression, kidney disease, hypertension and chronic obstructive pulmonary disease (COPD). The CDM Toolkit is available to all physicians and their staff.

Canadian Mental Health Association- "Bounce Back" and "Beyond the Blues"

Bounce Back: Reclaim Your Health is a new program designed to help people experiencing symptoms of depression and anxiety. The project is led by CMHA BC Division and funded by the BC Ministry of Health Services. Bounce Back offers a DVD video providing practical tips on managing mood and healthy living as well as a guided self-help program with telephone support. *"Beyond the Blues"* is an annual Depression Anxiety Education and Screening Day (DAESD). The event highlights successes with recovery and the availability of various treatment options as well as community resources and supports.

Integrated Health Networks (IHNs)

Integrated Health Networks in BC are a mechanism that supports and formalizes the critical linkages between community organizations and resources with primary health care and that realigns health authority and specialist services to integrate with primary health care. They are operated by Health Authorities under a Bilateral Agreement with the Ministry of Health Services. In VIHA, seven Integrated Health Networks have been established in thirteen communities across the island with a focus of employing primary health care staff to work with local networked physicians to assist them in utilizing quality improvement tools to best manage patient populations with complex chronic conditions.

Patients as Partners

A provincial initiative to ensure "voice, choice and representation" in regards to health care system design is attained. Current initiatives include the Health Literacy Collaborative.

Shared Care Funding

The Provincial Specialist Services Committee is comprised of representatives from the Ministry of Health Services (MoHS) and the BC Medical Association (BCMA). In 2009/10, a request for proposals was issued to promote collaborative care opportunities between family physicians and medical specialists. To date, VIHA has been successful in soliciting funding for 17 such projects.

VIHA Initiatives

Five-Year Strategic Plan

VIHA's Five Year Strategic Plan identifies both the development of a sustainable network of services and working with at-risk populations as priorities for 2009/10. This Framework is aligned and supports these goals.

Family Practice Council

The Family Practice Council's purpose is to function as an island-wide Department of Family Practice and discuss primary care opportunities and issues in a proactive manner. The Council is comprised of Medical Directors of Urban Family Practice and Chronic Disease Management, Rural Family Practice, Residential Care and Home Care, as well as Site Chiefs of Family Practice and Chiefs of Staff from smaller rural communities.

Chronic Disease Management Refresh Framework 2009/10-2011/12

The goal of this Framework is to develop a comprehensive Chronic Disease Management Service (CDMS) at the primary, secondary and tertiary levels of care for VIHA that provides:

1. Planned proactive care for chronic disease populations;
2. Timely intervention at the time of disease exacerbations; and
3. Enable patients and their families to function as vital partners within their care teams.

Other Program Strategies

Many VIHA Integrated Health Services (IHS) and Corporate Services strategies also link with and impact primary health care. These include the Population Health and Wellness Strategy, Seniors Health Strategy, VIHA Rural Health Framework, Aboriginal Health Plan, Care Continuum Strategy (IM/IT), Emergency Services Strategy, End of Life Strategy, Continuing Professional Development & Knowledge Translation Plan (CME), People Plan (HR) and the Capital Plan.

Primary Health Care Organizations (PHCOs)

VIHA operates three PHCO sites: Health Point Care Centre (Victoria), Ladysmith Family Practice Clinic and the Comox Valley Nursing Centre (Courtenay). Each of these PHCO sites provides primary health care services to a patient population within a local community. The service delivery and funding models for each of these programs vary.

Urgent Care Centres

Chemainus Health Care Centre Urgent Care unit and Ladysmith Community Health Centre Urgent Care unit are part of the VIHA network of sites that provide community residents and visitors urgent and emergent care. These units provide care within their defined scope and resources for Level 3 Urgent Care Centres, following Canadian Association of Emergency Physicians (CAEP) standards. In addition to Urgent Care, both Centres provide booked clinical procedure appointments (blood transfusions, re-hydration, IV antibiotics, outpatient procedures and cast care) and act as a primary health care resource for the community through proactive assessment, referrals and assistance in navigation within the health care system. The Centres are aligned with VIHA's Emergency Department program for the provision of educational support and in-servicing for the staff on the Units.

Nurse Practitioner Demonstration Project

In 2007, VIHA initiated a two-year demonstration project to integrate salaried Nurse Practitioners into three Fee-for-Service (FFS) physician practices. Early evaluation results show increased access, improved quality of care, improved patient satisfaction, improved provider satisfaction and increased fee-for-service billings.

Primary Mental Health Care Task Force

The Task Force is comprised of Program Leaders from both VIHA Primary Health Care and Chronic Disease Management Program and VIHA Mental Health and Addictions Services as well as representatives from family practice and medical specialists and the Canadian Mental Health Association. Current initiatives include the piloting of the Community Health Resource Directory (CHARD), Bounce Back, Practice Support Program Modules and the creation of a First Aid in Mental Health resource tools for primary care providers.

Home and Community Care (HCC) Partnerships

Home and Community Care has piloted projects in general practitioners' offices where a HCC case manager is attached to the practice and meets with the GP on a scheduled basis to review complex care needs of the physicians' patients living in the community. The Seniors Integrated Health Network (SARIN) is an example of this model of care delivery.

VIHA Quality & Patient Safety Initiatives

The Quality, Research and Safety (QRS) Portfolio supports primary health care initiatives through Accreditation supports and improvement activities (such as rapid cycle improvement model, root cause analysis and lean design approach).

Our Priority Strategies for Investment

The primary health care priority strategies for investment will embrace our business model, the Triple Aim Approach. To that end, we will seek out opportunities to work within our scope of services, employing the three Triple Aim elements: (1) patient / provider experience; (2) population health management; and (3) cost per capita. We will also invest in two Triple Aim enabling strategies: (1) facilitating the redesign of primary health care; and (2) system integration.

Patient & Provider Experience

1. ***Patients as partners:*** ensuring patients have established mechanisms for shaping primary health care systems, to include Integrated Health Networks, Primary Health Care Organizations and Nurse Practitioner services.
2. ***VIHA-wide Department of Family Practice:*** Develop a proactive, strategic island-wide Department of Family Practice and support other communities of practice through membership and support.
3. ***Self management supports:*** support primary care providers and partner agencies to help patients set and work toward their own health goals through collaborative care planning.
4. ***Access and attachment to practice:*** provide opportunities to learn about and support advanced access, group medical visits, lean design, partnerships with community agencies, and the introduction of other health disciplines in order to improve access and longitudinal attachment to services.
5. ***Measuring patient satisfaction:*** VIHA will continue investing in patient satisfaction surveys in our primary health care organizations, our Integrated Health Networks and our urgent care centres.

Population Health Management

1. ***Integrated Health Networks:*** Further development and growth of Integrated Health Networks with additional focus on those “at risk” populations (aboriginal, homeless, rural/remote communities, seniors, and people living with co-morbidities) for program investments. Through the business approach, we will work with island communities to facilitate access to primary health care services.
2. ***Municipal partnerships:*** VIHA will work with municipal partners to find innovation partnerships to provide psycho-social and other supports related to the broader determinants of health (recreation opportunities, food security, etc.).
3. ***Measurement of population health outcomes:*** Continued development of primary health care indicators (clinical) for program, executive and Board consideration. This will include the prototyping of community report cards.
4. ***Exacerbation management strategies for chronic diseases:*** Exacerbation management plans will be developed to enable primary health care providers to offer these tools to assist patient populations in better managing their care through a planned coordinated approach to self management to reduce avoidable ER visits, hospitalizations and Alternate Level of Care (ALC) designation.

Cost per Capita

1. **PHCO sustainability plan:** VIHA funded PHCOs will undertake a formal sustainability plan (18 months) to optimize their services based on a cost/benefit analysis.
2. **Co-location partnerships:** VIHA will continue to work with municipal and service agency partners to create co-location opportunities to improve access to primary health care resources and improve attachment to practice in Port Alberni, Sooke, Cowichan Valley and Oceanside.
3. **Attachment to practice:** VIHA will work with provincial, regional and local partners to increase attachment to practice with an initial focus on those living with chronic conditions. This includes quality improvement initiatives through our regional Support Team, growth of Integrated Health Networks and creation of Divisions of Family Practice.

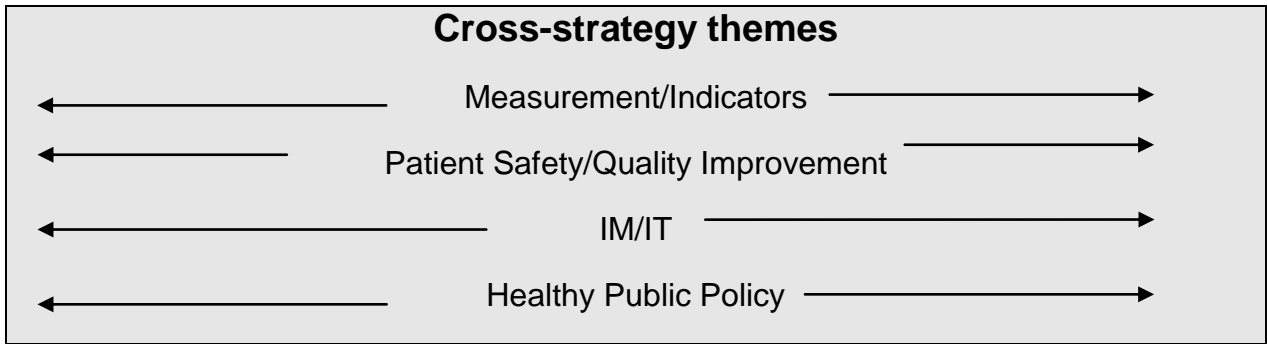
Redesign of Primary Health Care

1. **Regional support team:** Our VIHA Regional Support Team will work with identified communities across the island to engage physician practices and offer quality improvement courses through the provincial Practice Support Program, CDM Forums, primary health care developers and the IHN teams.
2. **Divisions of family practice:** Working in partnership with the Provincial Primary Health Council (Ministry of Health Services {MoHS}, BCMA and health authorities), VIHA PHC will play a facilitating role in supporting the development Divisions of Family Practice in various communities across the island.
3. **Nurse practitioner partnerships:** VIHA will continue to support the ongoing development of Nurse Practitioners working in primary health care environments, collaborating with the Professional Practice Office, the MoHS, university NP programs and physician offices across the island.
4. **Partnerships with ImpactBC.** VIHA will enter into a Working Relationship Agreement with ImpactBC with specific focus on integration of primary health care, community mental health services, public health and home and community care
5. **Collaboration with community agencies:** VIHA Integrated Health Network teams play a key role in developing and enhancing our partnerships with NGO (non-government organizations) in communities across the island.

System Integration

1. **General practitioner/specialist shared care:** VIHA will continue to support physician/specialist collaborative partnerships in a variety of venues, at the clinical site, in a shared care model, and in learning environments to aid in capacity building for managing complex cases.
2. **VIHA community health compacts:** VIHA will continue to support ongoing service integration across Integrated Health Service clinical program areas to ensure optimal care to the patient.
3. **Information management:** The VIHA Care Continuum Strategy will prototype several primary health care sites to support the evolution of best practices within the continuum, working towards one electronic medical record across the island.
4. **Telehealth / telemedicine:** VIHA will support opportunities to work with video and teleconferencing technology to develop telehealth and telemedicine learning sessions across island communities.

Triple Aim Elements: Initiatives			Enablers: Processes and Tools	
Patient and Provider Experience	Population Health Management	Cost Control	Redesign of PHC	System Integration
1. Patients as partners	1. Further growth of the IHN with a focus on “at risk” populations: Aboriginal, homeless, rural/remote communities, seniors and people living with comorbidities	1. PHCO sustainability plan (18 months)	1. Regional Support Team (Supports: PSP, CDM Forums, and IHN teams)	1. GP/Specialist shared care
2. Continue work with GP Divisions in various communities	2. Municipal partnerships re: broader determinants of health; - transportation, PSI/community recreation centres, etc.	2. Co-location partnerships (capital)- Port Alberni, Sooke, Cowichan Valley, Oceanside	2. Divisions of Family Practice	2. VIHA Community Health Compacts
3. Develop an island-wide, strategic Department of Family	3. Continued development of PHC indicators (clinical) for program, executive & Board consideration	3. Co-location partnerships (service delivery)	3. NP Partnerships in GP offices, PHCOs, other	3. IM/IT and the provincial ehealth strategy
4. Self-management supports	4. Exacerbation management strategies for chronic diseases	4. Work with partners to improve attachment to practice	4. Partnership with ImpactBC	4. Telehealth/telemedicine
5. Improved access			5. NGO collaboration	
6. PHCOs and urgent care centres				



Appendix A: Glossary of Terms

BCMA- British Columbia Medical Association

CHARD- Community Healthcare and Resource Directory (initial focus of this initiative will be for mental health and addictions)

CDM- Chronic Disease Management

CDMF- Chronic Disease Management Forums

CRNBC- College of Registered Nurses of BC

FM- Family Medicine

FPs4BC- Family Physicians for BC

GP- general practitioner

HCC- Home and Community Care

IHC- Integrated Healthy Communities

IHH- Integrated Health Home

IHI- Institute for Healthcare Improvement

IHN- Integrated Health Network

IHT- Integrated Health Team

IM/IT- Information Management/Information Technology

ITHA- Inter-Tribal Health Authority

MoHS- Ministry of Health Services

NGOs- Non-Governmental Organizations

NP- nurse practitioner

P3- Private, Public Partnerships

PITO- Physician Information Technology Office

PHCO- Primary Health Care Organization

PHC- Primary Health Care

PRIISME- VIHA Outpatient lab services has developed a diabetes recall program. Patients' names are given to the lab and the lab brings patients in for regular HA1C checks. Results are sent to the GP office. Currently active at the Cowichan District Hospital and WCGH- Port Alberni. Next site for implementation will be Campbell River.

PSP- Practice Support Program

PPO- Professional Practice Office

RFP- Request for Proposal

RSP- Regional Support Program

SARIN- Seniors at Risk Integrated Health Network

SSC- Specialty Services Committee

Telehealth/telehome care - provision of primary health care services to providers/patients and caregivers through electronic means using a variety of devices including but not limited to videoconferencing, telephone, and preventive devices within the patient's home with capacity for off-site monitoring.